CQRS Local User Guide

For

Commissioning Organisations

Version 1.8
January 2023

Disclaimer:

All names, images and any financial information are completely fictitious and have been created entirely for training purposes.

Some images may have dates that don't necessarily correlate. These images are for illustration purposes only.

Remember to take a look at our eLearning for a more interactive user experience. Click here to access this.

1.   About CQRS Local and its Benefits

What is CQRS Local?

CQRS Local is a web based system to manage payments for local incentive schemes – very much like the national version but with you in the driving seat!

The system will allow Commissioner's to set up and manage schemes – from a simple item of service option, to a complex weighted scheme; offer these schemes out to GP practices who then submit claims for payment; The Commissioning Organisation validate these claims and authorise payment and payment is made – simple and straightforward and all within a single system.

CQRS Local aims to:

- Provide flexibility in managing local incentives schemes through a payment tool that leads to prompt payments.
- Be a one-stop-solution for providers and Commissioners to claim and manage locally driven schemes that reflect local alities.
- Make payments without the need for practices to submit invoices following the approval of a claim.
- Offer reporting tools that enable ease in monitoring activity.
- Reduce the risk of inaccurate claims.
- Make it easier for providers to understand what payments have been made against the activities claimed.

Key Benefits for a Commissioning Organisation:

- A single, central point of access.
- Easily tracked and auditable data submissions.
- A reduction in time spent developing and administrating the local payment via spreadsheets.
- A standard and consistent approach to system configuration and administration.
- Integrated, seamless participation management .
- Increased reporting functionality .
- Access to external system support teams.
- Easier integration with other Commissioning Organisations, if required, in future.

Key Benefits for a General Practice (Service Provider):

- A reduction in the administrative overhead of submitting excel based claims
- Easier reconciliation of payment
- The ability to track all stages of the process following submission
- Enhanced reporting capability

2.   GP Practice Sign-up Process

The below processes will assist Service Providers with gaining access to CQRS Local depending on your chosen approval level set up.

1. The CQRS Local Team will set up a Commissioner as an Commissioning Account Administrator, who can set other users up at their Commissioning Organisation. These other roles could be; Commissioning User (tier 1), Commissioning Approver (tier 2) or Commissioning Finance.

2. A Commissioner will then email out a registration link to their GP practices' requesting for them to register for a CQRS Local account.

3. Each person at the practice who will be using CQRS Local will register for an account providing this has been agreed by their Practice Manager.

4. The Commissioning Account Administrator will receive notification of this request and will approve the account.

5. Once approved, an automated email will be sent to the Practice User who will click on a link and follow the on-screen instructions for account activation.

Key

CO – Commissioning Organisation. **SP** – Service Provider. PM/BM – Practice Manager/Business Manager

ℹ A CQRS Local Administration Guide can be found in the following location to assist you. Click here to view this.

3.   The End to End Process

This shows the end to end process in 3 steps. Please note that a GP practice will only ever see a service that they have signed up to and where this has been offered to them.

Step 1 – Commissioner creates a service, adds the service components and offers the service out to the Service Provider (s)

Step 2 – Service Provider prepares and submits Declaration*

Step 3 – Commissioner Approval Process
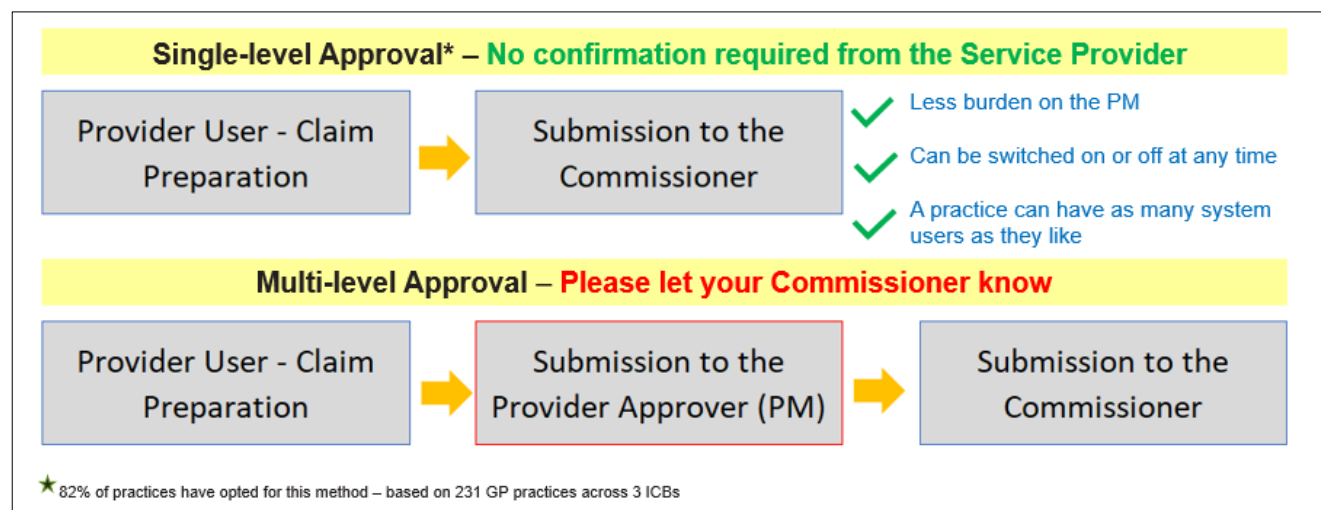   a) - Tier 1 Commissioner User – Inspecting the Claim
       b) - Tier 2 Commissioner Approver – Approving the Claim for Payment

*Refer to the section below titled 'Single and Multi-Level Practices Explained'

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4.   Single and Multi-Level Practices Explained

Some Service Providers currently have a single-level approval process and others have opted for multi-level approval. A single level process enables a Practice User to input acheivement data and submit this themsleves for Commissioning Organisation approval. These are usually smaller practices. Other organisations may prefer to opt for a multi-level approval process which will involve the claim being internally approved by the Practice or Business Manager prior to submission to the Commissioning Organisation.

The process below will show you the steps involved from beginning to end covering both the Commissioning Organsiation and the Service Provider when submitting claims. This covers both a high level and low level process view.

Single-level Approval* – **No confirmation required from the Service Provider**

Provider User - Claim Preparation → Submission to the Commissioner

✓ Less burden on the PM
✓ Can be switched on or off at any time
✓ A practice can have as many system users as they like

Multi-level Approval – **Please let your Commissioner know**

Provider User - Claim Preparation → Submission to the Provider Approver (PM) → Submission to the Commissioner

★ 82% of practices have opted for this method – based on 231 GP practices across 3 ICBs

5. User Roles and Accountabilities

Each Commissioning organisation and GP practice have a System Administrator/Super User who will create an account and give the necessary permisisons depending on the users' role and job accountabilities. The home screen for example may have fewer options than a co-worker.

For enquiries relating to user roles please consult your System Administrator/Super User in your organisation.

Below are two tables covering the roles available within CQRS Local and the typical permissions which can be carried out with that level of access. This can be configured.

Category	Action	Commissioner Admin	Commissioner Approver	Commissioner User	Commissioner Finance
User Accounts	User impersonation	✗	✗	✗	✗
	Create Account (by invitation)	✗	✓	✓	✓
	Edit Personal details	✓	✓	✓	✓
	Change Password	✓	✓	✓	✓
	Revoke User Access- Others' account	✓	✗	✗	✗
	Revoke User Access- Own account	✓	✓	✓	✓
	Approve personal details	✗	✗	✗	✗
	Request Additional Roles/Access to Organisation	✗	✗	✓	✓
	Approve Requested Roles/Access	✓	✗	✗	✗
	Opt In/Out of Email Notifications	✓	✓	✓	✓
	Withdraw Roles/Access	✓	✗	✗	✗
Approval	Approve Tier 1 Claims	✗	✗	✓	✗
	Approve Tier 2 Claims	✗	✓	✗	✓ *

* If a claim exceeds an internally agreed amount, a Tier2 Approver can submit the claim to a Finance User for them to approve.

This is optional and dependant on the organisations' policies. Tier2 can still proceed and approve the claim if, for example, they had verbal approval.

ⓘ Please note that some of the options you see in this user guide may not necessarily correspond with yours. If you think you require additional access roles, please consult with your line manager in the first instance.

6. Logging into CQRS Local & Forgotten Password

CQRS Local is a secure site and be can accessed from any web browser, such as Microsoft Edge, Internet Explorer, Chrome, or Firefox and does not need a VPN connection. Formally called N3, it will not require The Health and Social Care Network (HSCN) for a connection either.

Any user who wishes to register for an account should click on the link and follow the below instructions.

local.cqrs.nhs.uk

1. Click on the Register button where you will then be directed to the Registration page.
2. Enter in your email address.
3. Next is to enter in your ODS code (Organisation Data Service). If this is something you are unsure of, you can type in the name of the GP practice into the Organisation field.
4. Once you have done this, click on the Next button.
5. Now select the role you will undertake followed by your first and last name.
6. Finally, click on the Register button. Once your request is approved you will receive an email to confirm your account.

Please always ensure that you follow the password guidelines and remember to keep this password safe and not to disclose it to anybody – it's your ID and your responsibility.

Password guidelines: Passwords must be at least 8 characters and contain all of the following: upper case (A-Z), lower case (a-z), number (0-9) and special character (e.g. !@#$%^&*)

There is an option in the log in screen which will allow you to tick to 'Remember Me'. Do not use this option if you are logging onto a shared (public) computer.

Log in to CQRS Local

Email	Username
Password	Password

☐ Remember Me

→] Login   ● Register

🔒 Forgotten Password?

If you have forgotten your password, click on the Forgotten Password link. You will be presented with the following screen. Enter the email address that your account was registered with and click on the **Submit** button. When you reccieve your email from CQRS Local, follow the steps outlined.

Forgot Password

Enter your email address and you will be sent a link to reset your password.

Email

Submit   Cancel

ⓘ A CQRS Local Administration Guide can be found in the following location to assist you. Click here to view this.

7.   Switching Roles within CQRS Local

This is a convenient facility for users who have more than one CQRS Local user account to switch roles without the need to have multiple logins. Some Commissioning users for example will be set up as both the Commissioner Approver and Administrator. The following instructions will show you how you can easily switch between accounts.

Once you have entered your user name, password and logged into CQRS Local, you will be presented with a screen similar to the one shown below. Simply click on the account that you wish to use. You will then be taken straight to your homepage.

Multiple Roles Are Available

Commissioning Approver
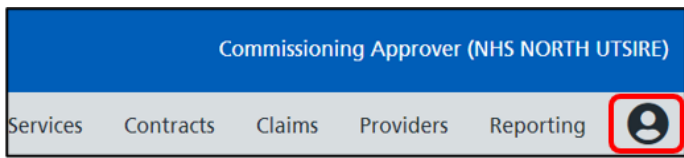NHS NORTH UTSIRE

Commissioning Account Administrator
NHS NORTH UTSIRE

If you are already logged in as one role, i.e. Commissioner Approver, and you wanted to switch to your Admin role, then you will need to do the following:

1. Click on your **profile** icon
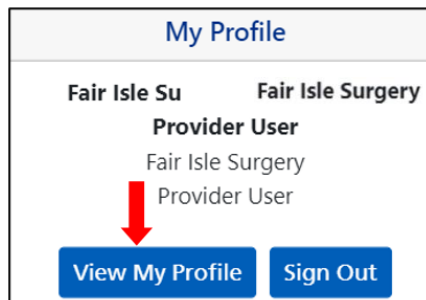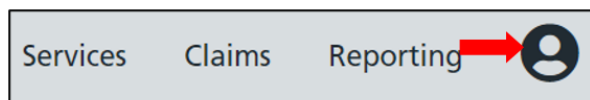
2. Next is to click on **Switch Role.**

3. You will then be asked to select your account (see image above showing both roles). After you have done this, you will then be taken straight to your CQRS Local homepage.

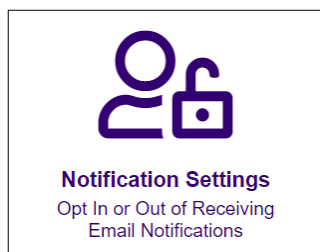# 8. Stopping/Setting up Email Notifications

To set up or stop email notifications, please follow the below process.

1. Click on the **View My Profile** icon located at the very right upper part of your screen.

2. Next is to click on the **View My Profile** button.

3. Click on the **Notification Settings** menu tile.

Notification Settings
Opt In or Out of Receiving
Email Notifications

4. Tick or untick the send me notifications option.

5. Click **Save** to save your preferred settings.

9. Your CQRS Local Home Screen

When you log in to CQRS Local you will be presented with your home screen. Again, as mentioned previously, you may not have visibility of all the below functions.
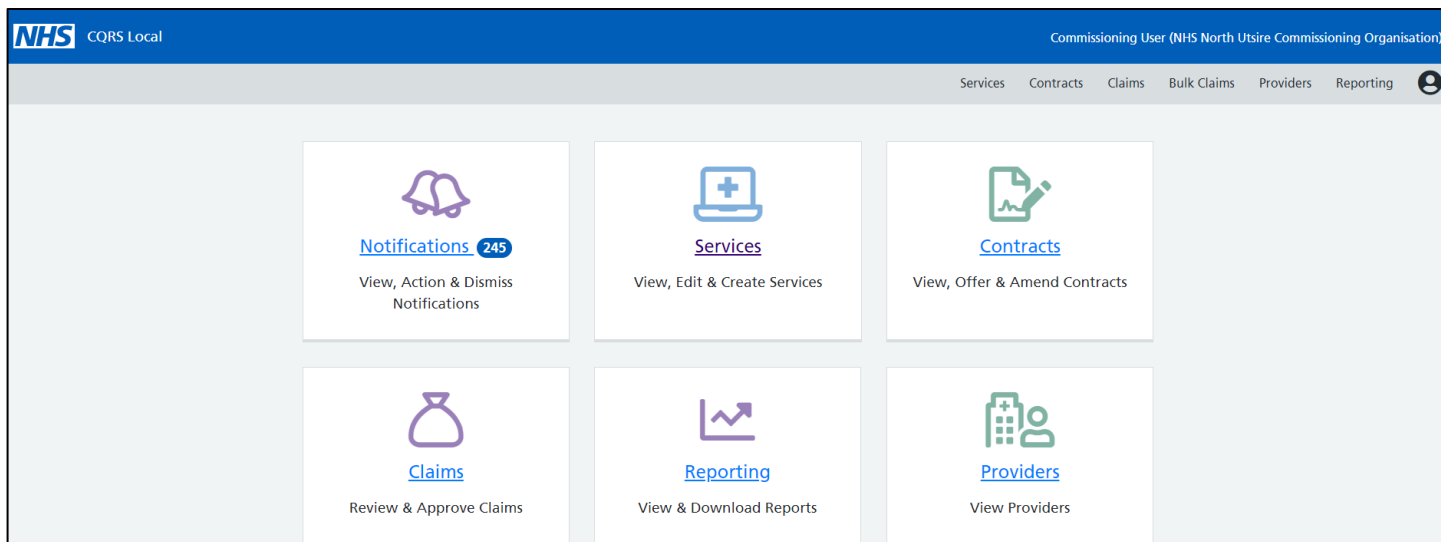
The screen features a number of menu tiles and will take you directly to that particular section in the system. Each of the tiles are linked to the options on your menu bar.
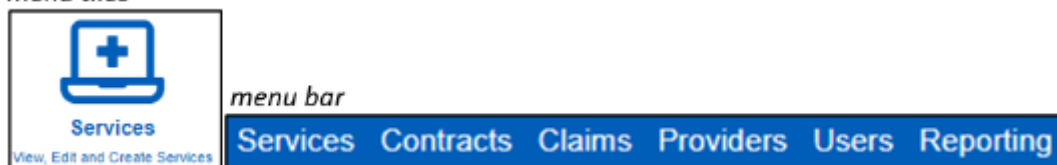
A number in a green box as shown below in Notifications, indicates that there are a total of 10 notifications for you to be aware of. Clicking on the menu tile will open the message centre. Messages in blue indicate that they have not been read. Your role and system set up will determin the type of messages that you will see. For example, an Approver will have notifications advising them that there are claims that need their approval.

Notifications by Status:	Notifications by Type:
All Statuses	**Claims & Approvals**
Unread Items For Action	Approval Period Expired
Unread Items For Information	Claim Approved
All Items For Action	Nearing Approval Period End
All Items for Information	Pending Commissioner Review (L1)
	Services, Components & Contracts
	New Contract
	Service Created
	Service Published

System Notification for a Commissioner alerting them that there is a claim Pending Commissioner Review (L1).

Claim from Fair Isle Surgery in 2 months	Pending Commissioner Review(L1)	View ∨

Below is a matrix showing which functions will be available depending on your user role. These functions will appear on your CQRS Local homepage as menu tiles and will also show at the top of your screen as a link too.

Organisation - Commissioning								
Available Functions								
User Role	Services	Contracts	Claims	Bulk Claims	Providers	Reporting	Payment File	Users
Commissioning User	√	√	√	√	√	√		
Finance User	√	√	√				√	
Admin User	√	√	√		√	√		√
Super User	√	√	√		√	√		√

Organisation - Service Provider								
Available Functions								
User Role	Services	Contracts	Claims	Bulk Claims	Providers	Reporting	Payment File	Users
Provider User	√		√			√		√
Admin User			√			√		
Finance User			√			√		

10.   Switching On/Off Multi-level Approval

By default, all GP practices are set to be a single level approving practice (for further information on this, please refer to the section The End to End Process – High and Low Level View)

1. From your CQRS Local homepage, click on the **Providers** menu tile.

2. Locate your GP practice and click on the **View** button.

3. Tick or untick the Multi-level approval box.

4. Click **Save.**

11.   Tariff Currency and Bandings

This section will aid you with deciding which tariff currency is right for your service as well as useful information relating to bandings and how they work.

	Tariff	Meaning
1	Per Unit	Per Patient or Per Test

2	Retainer	Retainer is that you will deliver a service no matter how many patients you see. A Commissioner may ask for evidence to be provided of tests completed. There may be a certain number for the Commissioner to honour payment. These are usually payable yearly.
3	Actual Population Per Item	Similar to 4 - but per Patient or Per Test
4	Actual Population Retainer	Actual Population retainer – this would usually be a small amount often circa £1 per patient paid over the year and often split quarterly (i.e. if £1 per head per 10000 patients then they would be paid £2500 per quarter to deliver the service for the year as and when required). For example – a treatment room / out of hospital care service would pay circa £1.27 per actual patient per year to provide a number of elements as and when required such as minor trauma/blood samples/ear syringing/ dressings etc.
5	Weighted Population Per Item	Similar to 1 but these are based on weighted population.
6	Weighted Population	Weighted population retainer – as per the above but used for a service for a clinical condition that could have more of an impact on patients of a certain age group / depravation etc. where some practices would see more activity or that would need more time and effort to provide the same service to their patients demographic.
7	Bandings – Static Activity and Static Percentage & Sliding Scale	Bandings can be used by Commissioners for performance related payments. You could use the Static Activity where achievements that meet a certain threshold will determine a higher financial return for the provider. These can be calculated as patients seen or procedures undertaken. Static Percentage shows where performance will be related to percentage complete and based upon them you get a different tariff. The sliding scale is set between 0 and 100 % with every single step up by a percent equals a different tariff amount.

Per Unit - Static Activity

You must enter a minimum of one From / Tariff pair. Each From value should be greater than the last.

From	To	Tariff
1	99	5
100	199	7.50
200	299	8.50
300		10

There is also a useful calculation tool to help Service Providers work out potential income. Simply enter in the number of patients you have seen or forecast to see and click on the Calculate button.

Calculation Example

After entering band values, use this section to check that for a given claim, the expected claim value is returned.

Claimed	Claim Value
200	1700.00

[Calculate!]

You will need to select the Banding type required for these scheme.. The example shown above uses the Static Activity. The Static Percentage could be used for a certain cohort of patients. For example, the cohort of your registered patients who are being prescribed Warfarin and are due to have a review – the following would then be payable per percentage of patients who have had their review undertaken.

Banding Type *

Static Activity ⌄

Static Activity
Static Percentage

BandingType

Static Activity ⇕

✓ Use Sliding Scale

The sliding scale option is used for both percentages and banding.

Per Unit - Static Percentage

You must enter a minimum of one **From (%)** / **Tariff** pair. Each **From (%)** value should be greater than the last. You can use two decimals places.

From (%)	Tariff
0	5
10	7.50
25	9.00
50	10
100	15

12. A Commissioner Creating a Service

This section will help you understand how to use the system as a Commissioner to create a new service, add components and create contracts. Please note that, due to user permission levels, some of the options you see in this user guide may not necessarily correspond with your live system. If you think you require roles with additional access, please consult with your local Admin User.

Creating a New Service

1. Click on **Services** located in the upper part of your screen or alternatively select the menu tile from your homepage.

Services   Contracts   Claims   Providers   Users   Reporting   👤
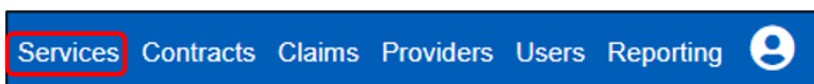
2. Select the **Financial Year** this Service will be running in.

3. Next click on **New Service**.

4. You will then be presented with the Service information screen. Below is a screenshot with corresponding letters next to each section to aid you with completing each part correctly.

A. **Name** - choose a name for the Service – this may, for example be Minor Surgery. A message will appear if your chose a name that is already in use.

B. **Financial Year** – is the period in which the Service will run.

C. **Use PCSE for payments** - this will work in exactly the same way as the National System, or simply leave unticked if you have an agreement in place to pay off system.

D. **Paycode Description**– this will determine which budget this particular service will be paid from. Please choose the most appropriate selection carefully and consult with your Finance Team if in any doubt. The paycodes used will also determine which Service Provider Contract Type they can be used for. The Minor Surgery DES paycodes highlighted below illustrates that these codes are suitable for GMS, APMS and PMS Contracts from their last letter. Minor Surgery DES [DEMSU**G**, DEMSU**A**, DEMSU**P**]

E. **Description** – any details relating to the service description. You could just enter what the name of the service is.

F. **Has Claims Windows** – Use this option if you require your Service Providers to submit their claims during a specified period of time.

G. **Claims Submitted On Behalf Of Practice By Commissioner** - claims submitted on behalf of Practice by Commissioner, this would be an agreed alternative of Service Provider data submission where the Commissioner or a CSU will submit a Claim (s) on behalf of the practice.

H. **Service Specification** – you may have already emailed this document out to your Service Providers but having the document within the system will make locating it very convenient. We will see how this document is accessible later on in the guide. To upload the document, click on the browse button to locate it. Once you have selected the document, click Open which will automatically attach it.

I. **Re-set Form/Save/Next** - allows you to clear all the fields you have filled in if you wish to start again, **Save** will enable you to save the form to come back to it at a later time and **Next** will take you to the next page.

5. Enter the **Name** of your service - in this example are service is going to be Minor Surgery.

6. **Financial Year** can remain as it is unless you are adding a service in preparation for a new year.

7. Place a tick in the **Use PCSE for payments** or simply leave unticked if you have an agreement in place to pay off system.

8. **Claims submitted on behalf of Practice by Commissioner** is covered below. For additional guidance, please refer to - Commissioner Submission on behalf of a Service Provider.

9. Choose the **Description** for the Service. This may be the same as the Service Name.

10. **Upload Service Specification Document** – A Service Specification Document is the contract delivery requirement between the Commissioning Organisation and the Service Provider. Click the **browse** button to locate the document on your computer.

11. Once the file has been selected, click the **Open** button.

The file will then be uploaded to CQRS Local. You can futher documents if required – just follow the same process.

The Service details have now been entered. The next stage is to add the system components.

12. Click on **Next** which is located on the bottom of your screen. This will take you to the Components page.

13. Then click the **Create Component** button.

Adding Components

A Component is an activity that will be undertaken by the Service Provider in conjunction with the Service that they will be providing. For this particular example, Minor Surgery service, our components will be; Excisions, Incisions and Injections.

You will then be presented with the Component screen. Below is a screenshot with corresponding letters next to each section to aid you with completing each part correctly. Please note that if you wish to add several components they would need to be done separately. For example, minor surgery will include 3 components for Service Providers to claim against which are:

Component 1 – Injection (indicate drug name if required)
Component 2 – Incision
Component 3 – Excision

A. **Name** – This is the name of this particular component. See above for details.

B. **Claim Frequency** – You can specify when a Service Provider can make a claim for these Components. The frequencies are: Monthly, Quarterly, Bi-Annually or Annually.

C. **Tariff Currency** – These are: *Per Unit, Retainer, Actual Population Per Item, Actual Population Retainer, Weighted Population per Item and Weighted Population Retainer*. Please see the tariff currency table below for further clarification as to what these mean.

D. **Base Tariff** - If you choose, for example, Per Unit for the Tariff Currency and pay a Base Tariff of £10, this will in theory mean that you will pay £10 per patient or per test etc.

E. **Description** – You can add a little further information here as to what the component is

F. **Evidence Required** – A Commissioner may request that a Service Provider supplies and uploads evidence to support these claims. The Commissioner will indicate in the grey box what type of evidence is required and the preferred format for this to be produced in. **It is paramount that whenever a piece of evidence is provided it must not contain any information that would identify a patient**. If in doubt please consult with your Caldicott Guardian for further advice.

G. **Evidence Required Details** – see above

H. **Accepted Files** – If you request that evidence is provided to support a claim, you can specify which files you will accept.

I. **Add Bandings**. Click here to learn all about Tariff Currency and Bandings

J. **Reset Form & Save** -Reset form allows you to clear all the fields you have filled in if you wish to start again, **Save** will enable you to save the form to come back to it at a later time

14. When you have filled in the details of your component, it will look similar to the example below. If you have specified a requirement for evidence, please be clear and descriptive.

ℹ️ It is advisable to copy the Evidence Required information text so that you can paste it into all the proceeding text box fields.

15. When you have completed the form, click **Save**.

16. Your first component has now been successfully added to the system. Should you wish to edit this, click on the **Edit** button. This will allow you to edit the component name, Tariff Currency, the Base Tariff, Claim Frequency as well as the Evidence Required information box. There is also a Delete option if you wish to remove it. Should this be the case, remove it from the system and start back at the Create Components section and start again. For details about the Schedule, refer to section Schedules (Claim Windows).

You can click the **Create Component** button again to add more components to the service. There is no limit as to how many components you can add to a service. Follow exactly the same process as above.

All of the Components have now been entered onto the system. In this scenario we have requested that the Service Provider supplies evidence for each of the 3 components, this means that they will be uploading and submitting the same evidence document 3 times – this will not take long to do.

Service	Components	Review									
Create Component +											
Component Name	**Tariff Currency**	**Base Tariff**	**Frequency**	**Claim Schedule**	**Start Date**	**End Date**	**Evidence Required**				
Excisions	Per Unit	£88.91	Quarterly	Standard	01/04/2021	31/03/2022	Yes ⓘ	Schedule	Edit	🗑
Incisions	Per Unit	£88.91	Quarterly	Standard	01/04/2021	31/03/2022	Yes ⓘ	Schedule	Edit	🗑
Injections	Per Unit	£45.36	Quarterly	Standard	01/04/2021	31/03/2022	Yes ⓘ	Schedule	Edit	🗑

ⓘ Please note that a Financial Year cannot be changed once a component is created for this Service.

Reviewing and Publishing

Reviewing and publishing allows you to check to ensure that any service entered onto the system is well detailed and correct as once the service has been published the service and its components cannot be edited.

17. Now that all of the Components have been entered, the next step is to review and publish the service. Click on **Review** which is located on the upper left-hand side of the screen.

18. It is a system requirement to confirm that you wish to publish the service. Place a tick in the box and click the **Publish** button. Please note that you will not be able to publish the service if you haven't placed a tick in the box. Remember that once published, services and components cannot be edited.

Service	Components	Review

Review Service

Name			**Start Date**		**End Date**		**Paycode Description [Paycodes]**	
Minor Surgery Service.			01/04/2022		31/03/2023		Minor Surgery DES [DEMSUG,DEMSUA,DEMSUP]	

Name	**Description**	**Tariff Currency**	**Base Tariff**	**Frequency**	**Claim Schedule**	**Start Date**	**End Date**	**Evidence Required**	
Excisions	Please enter the number of excisions undertaken.	Per Unit	£88.91	Quarterly	Standard	01/04/2022	31/03/2023	Yes ⓘ	Schedule
Incision	Please enter the number of incisions undertaken.	Per Unit	£88.91	Quarterly	Standard	01/04/2022	31/03/2023	Yes ⓘ	Schedule
Injections	Please enter the number of injections undertaken.	Per Unit	£45.36	Quarterly	Standard	01/04/2022	31/03/2023	Yes ⓘ	Schedule

☑ Select to confirm you wish to publish this service (once published, services and components cannot be edited)

✓ Publish ⬅

A message will temporarily appear to tell you that the service has been successfully published. The service is now published and showing that is has 3 components.

Home > Services

#	10 ⏶	Search Service Name	🔍	+ New Service			
Service Name		**Commissioner Submission**	**Date From**	**Date To**	**Status**	**Components**	**Action**
Minor Surgery 21/22			01/04/2021	31/03/2022	Published	3	View

Creating a Contract

The next step is to create a contract. Creating a contract is the point in which you can decide who you are going to offer this Service to – it may be one provider or all providers within your area.

19. Click on **Contracts** located in the upper right-hand side of your screen.

20. Next, click on **New Contract**.

21. In the **Contract Name**, enter the name of the Service. This example will be: Minor Surgery Service.

22. Click on the **Next** button, or you can click on the **Providers** Tab.

23. If the Service is going to be offered out to all providers, use the Select All tick box. You can also select individual practices if this is your preference.

24. Click on the **Next** button, or you can click on the **Services** Tab.

25. You can use the search facility to locate your service. Enter the name of the service and click on the magnifying glass.

26. When you have located your service, place a tick into each of the components. You can always use the **Select** button which will select them all.

27. Click on the **Next** button, or you can click on the **Review** Tab.

28. A confirmation screen will appear showing the list of the participating providers and the service (s) that are going to be offered out.

29. Place a tick in the check box at the bottom of the page. This is to confirm you wish to send this contracted activity to the selected providers. Now click **Confirm**.

You will then receive a temporary on-screen notification advising you that the service is now live.

ⓘ   To see how a Service Provider will input and submit their achievement, please refer to the training material on the Academy for information.

13.   The Commissioner Approval Process

Once a Service Provider has submitted their achievement it will come to come to the Commissioning Organisation to review. This section will help you understand how to use the system, as a Commissioner, to undertake the approval process to ensure that Service Providers are paid seamlessly, quickly and efficiently.

Please note that most Commissioning Organisations have opted to have an internal two-tier approval process. This means that once the claim has been approved by tier 1 it then moves to tier 2 approval, where a user with financial responsibility will proceed to authorise the claim for payment.

ⓘ   In this scenario we will be undertaking all actions associated with a two-tier process. It also includes what to do if the claim value exceeds a permitted approval amount.

Tier 1 Approval

1. Firstly, a Commissioning User will need to log in to CQRS Local to proceed with this approval.

2. Click on **Claims** which can be found in the top right-hand corner of the screen or alternatively select the Claims menu tile from your homepage.
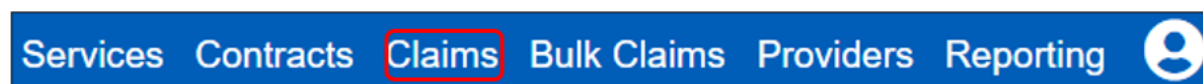

3. Your claim will be visible on the claims page. Here will detail the financial rating. The rating categories are as follows:

- Category 1- Low Risk - Claims with payment of less than £15,000
- Category 2- Medium Risk - Claims with payment of £15000 and above but less than £50,000
- Category 3- High Risk - Claims with payment of £50,000 and above

4. The submitted claim will detail; the claim ID, the Provider who submitted the claim, submission date, status and estimated value.

5. Click on the **Review** button.

6. At this stage it is important that any evidence files submitted by the Service Provider are examined thoroughly to ensure accuracy before approving the claim (s). Should the claim be declined for any reason, refer to section Declined Claims by the Commissioner. To check submitted evidence files, click on the View Evidence Files icon located in the Evidence column.

7. Firstly, ensure that the file name is correct. Underneath **Action** click on the **download file** button.

Evidence upload ✕

Component: Excision

| File name	Action
Minor Surgery Claim Form.xlsx	📤 🗑️

| Choose file... | Browse |

Valid types: *.docx, *.xlsx, *.doc, *.xls, *.odf, *.pdf

Evidence requirement details:
Please complete the Excel document titled Minor Surgery Claim Form. Please read the guidance before completing and submitting. Thank you.

Close

8. Your file will automatically download to your computer and is retrievable from your downloads section on your computer. You can access your downloads by simultaneously pressing both the Windows key and the letter 'E' on your keyboard and navigating to your downloads section.
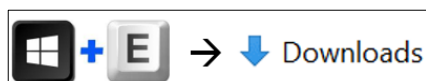
Open the required evidence file.

Minor Surgery Claim Form for referred patients LIS 2021/22 claim (LIS)		North Utsire NHS

ONLY COMPLETE GREEN CELLS	
Contact Name	Jessica Finn
Contact Email Address	jessica.finn@fis.nhs.uk
Practice Code (click on yellow cell and select from drop down List)	P58490
Practice Name	Fair Isle Surgery
Claim Month	Jun-21

COMPLETE YELLOW CELLS FOR ACTIVITY CLAIMED			
Minor surgery			
PROCEDURE	TYPE	QUANTITY	PAYMENT
Number of Incisions completed (£88.91)	INCISION	17	£1,511.47
Number of Excisions completed (£88.91)	EXCISION	23	£2,044.93
PROCEDURE	NAME	QUANTITY	PAYMENT
Injections (£45.36)	Depo-Medrone	25	£1,134.00
Injections (£45.36)	Depo-Medrone with Lidocaine	15	£680.40
Injections (£45.36)			£0.00
Injections (£45.36)			£0.00
Please list name of Injections separately for example: Depo-Medrone, Lidocaine, Depo-Medrone with Lidocaine			£5,370.80

9. To close the evidence file, you will need to click on the X button [— ▢ ✕] in the very top right hand corner of your screen. The file can be filed away if desired by using the File → SaveAs function.

ℹ️ If saving the file, it may be useful to save it with the following naming convention:

Minor Surgery Claim Form_P58490_Fair Isle Surgery_ June 2021

10. Once you have checked the claim and the supporting documentation and wish for it to proceed to the next level of approval (tier 2), place a tick in the **Approve** box (es). You can also use the Approve All box to select all the boxes.

11. Lastly, you will need to click on the **Send For Approval** button.

You will then receive a notification advising that the Claim has been submitted for payment approval. The Service Provider will also see this too within their Claims screen.

Tier 2 Approval

Only users with a Commissioning Approver account can authorise a tier 2 claim. It must be also noted that the same person cannot authorise both tier 1 and tier 2 in any claim.

1. Click on **Claims** which can be found in the top right-hand corner of the screen or alternatively select the Claims menu tile from your homepage.

2. Click on **Review**.

3. Even though the supporting evidence has been checked by a tier 1 Commissioning User, it is your responsibility to check that everything is correct as this is the ultimate stage of approval before payment is made to the Service Provider. Check each file by clicking on the View Evidence Files buttons as detailed above (please refer to section 6 in Tier 1 Approval for guidance). Should you decide to decline the claim at this stage refer to section Declined Claims by the Commissioner.

4. If you are satisfied with the supporting evidence as well as the claim amount, place a tick into each of the boxes in the **Approve** column as shown below.

5. Next is to place a tick into the box to **certify** that the above claim can be approved for payment.

6. Lastly, click on **Approve For Payment**.

Please note that if you are unable to click the Approve or Decline boxes it may mean that you may be outside of the Approval Window. For information on Approval Windows, please refer to section Schedules (Claim Windows).

A screen message will be briefly displayed to confirm that the '*Claim has been approved for payment'*. The system status will now read – *'Claim Approved'* and this indicates that the payment process will begin. The Service Provider will also see this within their Claims screen.

Finance Approval

If your claim reaches a certain claim value, you can refer it to a Finance person to approve. This is optional and each Commissioning Organisation will have their own protocol in handling such claims. If you have any queries regarding the value of a claim (s), please discuss this with your finance department.

To refer such claims follow the below steps:

1. Click on the **Send to Finance** button.

2. You will then need to specify a reason, this will be read by the Commissioner Finance person.

3. Once you have entered a reason, click **Confirm**.

This will immediately go the Finance person to approve. After they have approved the claim it will go through the PCSE process or other agreed payment method if not using PCSE.

14.   Declined Claims by the Commissioning Organisation

Most Commissioning Organisations will have a 2-tier approval process for all claims, these are:

- A tier one Commissioner will inspect the claim (s) for a correct evidence file and that units/achievements attained tally up.
- A tier two Commissioner will approve the claim from a financial perspective.

A Commissioner may reject a claim, if for example, an incorrect evidence file was submitted or that the Units/Achievements appear too high or too low. To reject a claim:-

Claim Components

Service	Component	Approval Window	Status	Tariff	Units/Achievement	Estimated Value	Evidence	Approve	Decline	Action
Warfarin Monitoring 2021	Warfarin Monitoring	11/06/2021 - 16/06/2021	Pending Commissioner User Approval	£27.00 Per Unit	27	£ 729.00	👁	☐	☐	

🗎 Save For Later   ⊘ Decline   → Send For Approval

1. Place a tick in the **Decline** box.

Claim Components

Service	Component	Approval Window	Status	Tariff	Units/Achievement	Estimated Value	Evidence	Approve	Decline	Action
Warfarin Monitoring 2021	Warfarin Monitoring	11/06/2021 - 16/06/2021	Pending Commissioner User Approval	£27.00 Per Unit	27	£ 729.00	👁	☐	✓	

🗎 Save For Later   ⊘ Decline   → Send For Approval

2. Enter your reason for declining the claim followed by clicking on the **Save** button.

Component Declined   ✕

Date: 17/05/2021
Please state a reason for declining this service component:

You have submitted an incorrect evidence file. Please remove from the system and re-submit. Thank you.

minimum 20, maximum 200 characters

History

➡ Save   Cancel

3. Once you have clicked Save, click on the **Decline** button.

Claim Components

Service	Component	Approval Window	Status	Tariff	Units/Achievement	Estimated Value	Evidence	Approve	Decline	Action
Warfarin Monitoring 2021	Warfarin Monitoring	11/06/2021 - 16/06/2021	Pending Commissioner User Approval	£27.00 Per Unit	27	£ 729.00	👁	☐	✓	🕓

🗎 Save For Later   ⊘ Decline   → Send For Approval

The status will show as '*Commissioner User Declined'* which will be visible to both the Commissioner and the Service Provider.

The Service Provider will receive a notification that the claim has been declined. They can click on the Notification menu tile or they can click on the Claims menu tile. A new history icon will now appear which will contain the declined notes.

The below box will detail the declined notes inputted by the Commissioner as well as the name and email address of the person who declined the claim. This is convenient for any communications that may take place to discuss it.

4. Click the **Close** button to exit the message.

ⓘ If any part of the claim was declined – the whole clam is declined. The Service Provider will then correct only the component that was declined and re-submit. Only the re-submitted component will need to be approved and not each of the components again.

The below image shows a claim featuring ECG Monitoring and Minor Surgery which has been submitted together. As you can see, the Minor Surgery components are approved, however, the ECG Monitoring is declined. This will mean that the whole claim (including Minor Surgery) will be returned to the Service Provider who will only need to action the component that was declined.

The Service Provider will see the below screen. The History button will provide details of why the claim was declined. The Units/Achievement box for the declined claim will become editable and the figure within it can be changed if this was a requirement. Please note that all other Units/Achievement boxes cannot be edited.

Once the Service Provider has made the necessary changes, they will click on the **Submit Claim** button which will be sent back to the Commissioner for approval.

Once returned to the Commissioner, it will look similar to the image shown below. The ticks in the Approve boxes for the other Services you have approved will remain ticked apart from the one which was declined. Once you have checked and approved the revised service/component, place a tick in the **Approve** box and click on **Send For Approval.**

Note – you can be reminded of why the service/component was declined by clicking on the history icon under Action.

15.   Commissioner Offering out an Existing Service

If the service you would like to offer out has already been created and you wish to use re-use it, this is a very simple process to follow as you will only need to send out the contract to your Service Provider (s). This could be, for instance, for a new provider who has come onboard and wishes to participate.

The following instructions will aid you with undertaking this.

1. Click on **Contracts** located in the upper part of your screen.

2. Click on **New Contract**.

3. Please refer to the section – A Commissioner creating a Service and follow the instructions located under Creating a Contract for all the necessary steps to complete this process.

16.   Making a Change to a Service Offering

The following instructions will aid Commissioners to include a Service Provider (s) into a Contract/Service offering where they had previously not included them.

Example: Phlebotomy was originally offered out to 25 Service Providers and later the Commissioner had a change of plan and wanted to include all Service Providers.

ℹ️ Before you follow the below, you must make sure that there aren't any claims (for this service) Pending Approval. These must be processed first otherwise you will not be able to make the amendments.

1. Click on **Contracts.**

2. Locate your Contract and click on **View.**

3. Scroll down to the bottom of the screen and click on **Amend.**

4. Click **Confirm** on the on-screen message.

5. Select the **Providers** tab at the top of the page.

6. Place a tick in the boxes for the providers who were previously excluded or use the **Select All Providers** at the top of the screen.

7. Click on the **Services** tab and make sure that the original service is still selected.

8. Click on the **Review** tab at the top of the page..

9. Place a tick in the confirm box.

10. Click the **Confirm** button.

If this was successful, you will see a similar message at the top of the screen.

The contracted activity 'MSSAT' is published successfully

To check how many providers this has been offered to, follow these instructions:

1. Click on **Contracts.**

2. Search for your Contract Name

3. The headers at the top of the screen will list Providers which will give you a total number of providers this Service has been offered to.

17.   Ending /Expiring a Contract

There is now the ability to end/expire an entire contract and doing so will prevent Service Providers from making any further claims against the services in the contract. The contract status will be shown as 'Expired' on the list of contracts.

Please note that any pending claims (First or Second Commissioner) will not be impacted by this.

1. From your home screen, click on the Contracts menu tile.
2. Locate your Contract (Service) and click on the **View** button.

Contract Name ⬍	Components ⬍	Providers ⬍	Status ⬍	Action
Near Patient Testing Levels 1&3 2022/23	2	27	Live	View
Anti Coag Level 1 2022/23	1	27	Live	View
Minor Surgery LES 2022/23	4	4	Live	➡ View
Enhanced Health in Care Homes 2022/23	1	27	Live	View

You will find the names of the providers who have signed up to that particular service.

3. Click on the **Expire** button.

4. Confirm that you wish to expire this Contract.

We now see an Expired Status and not further claims can be made.

Contract Name ↓↑	Components ↓↑	Providers ↓↑	Status ↓↑	Action
Near Patient Testing Levels 1&3 2022/23	2	27	Live	View
Anti Coag Level 1 2022/23	1	27	Live	View
Minor Surgery LES 2022/23	0	0	Expired	

18. Commissioner Submission on Behalf of a Service Provider

This option is available to Commissioning Organisations who makes claims on behalf of their Service Providers. This is the ideal option if you are processing just a small number of claims. If you are only submitting a larger number of claims, you may wish to use the Bulk Claims option.

Before carrying out this task it is essential that you are familiar with all the steps involved in a Commissioner creating a service, adding components and publishing it. For information on this, please refer to A Commissioner creating a Service.

When undertaking a Commissioner Submission, it is expected that both the person submitting the claim and the Service Provider are in full agreement to this being carry out and that steps are in place to provide all relevant supporting evidence where this has been requested.

This function can only be carried out by a Commissioner User (tier 1)

Also note that Bulk Claims can only be made as per the schedule. See an example below:

ⓘ Depending on the approval level process, the following will occur. Please refer to the following section for confirmation - The End to End Data Submission Process – Single or Multi Level Approval)

Single-level Approval	The claim (s) will go straight to the Commissioner Approver to approve
Muti-level Approval	The claim (s) will go to the Provider Approver to approve and then to the Commissioning Approver

Creating a New Service – for submission on behalf of providers

1. When creating the Service, fill in all the necessary service details as normal. Once you have completed this you will need to place a tick in the *Claims Submitted On Behalf Of Practice By Commissioner* box as shown below.

2. Click the **Next** button located at the bottom of the page.
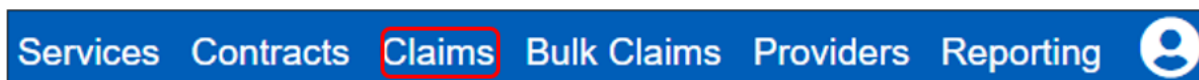
3. Add all of the necessary Components.

4. Review and Publish the Service.

5. Create a Contract and send it out to your Service Provider(s).

ℹ️ Users will only be able to undertake the next steps if the appropriate user permissions are in place. If you are unable to do the next steps, , please consult with your line manager or CQRS Local Administrator.
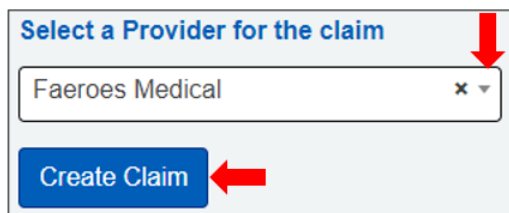
6. Click on **Claims** which can be found in the top right-hand corner of the screen.

7. Click on **New Claim**.

8. Pick your Service Provider(s) from the drop-down menu and select it.

9. Click on **Create Claim.**

Please note that if you receive the following message *'There are no services ready for claim'* this will indicate that the claim is outside of the schedule. For further information on schedules please refer to section Schedules (Claim Windows).

10. Enter in the Units/Achievement and upload any supporting evidence documentation if required to do so.

11. Click on the **Send For System Approval** button located at the bottom of the page.

A message will briefly display saying *'Claim has been sent to Provider Admin for approval'*.

Provider Approver approving the claim

Unlike the normal process of provider-based submissions, the provider user will not be required to make the claim as this part has already been done on their behalf. In all cases the claim will go straight to the Provider Approver.

12. Upon logging into CQRS Local, the Provider Approver will see the claim once they have clicked on the Claims menu tile located on their CQRS Local homepage.

13. Click on **Review.**

Claim Id	Claim Name	Creation Date	Submission Date	Approval Date	Status	Estimated Value	Action
677	Claim from Faeroes Medical	19/04/2021	12/04/2021	11/05/2021	Claim Approved By Commissioner Approver	£3694.00	View
679	Commissioner claim for Provider: Faeroes Medical	17/04/2021			Pending Internal Approval	£1080.00	Review
678	Claim from Faeroes Medical	01/04/2021	12/04/2021		Pending Commissioner User Approval	£1554.00	View

14. Check to make sure that all the information entered on your behalf is correct including any evidence documentation. Should there be any queries relating to this, then please liaise with the organisation who entered this information in the first instance. If this is the case, you may wish to click on the **Save For Later** button so that you can carry on using CQRS Local for other activities.

15. If you are satisfied with the information, click **Submit Claim.** A brief message will appear informing you that the Claim has been *submitted to Commissioner for approval.*

Claim Components

Service	Component	Claim Window	Status	Tariff	Units/Achievement	Estimated Value	Evidence	Approve	Decline	History
Anti Coagulation Therapy	Anti Coagulation Therapy01	17/04/2021 - 10/05/2021	Pending Internal Approval	£180.00 Per Unit	6	£ 1080.00	👁	☑	☐	

C Reset Form　　🖫 Save For Later　　→ Decline　　→ Submit Claim

The claim will now have this status: *Pending Commissioner User Approval.*

Claim Id	Claim Name	Creation Date	Submission Date	Approval Date	Status	Estimated Value	Action
677	Claim from Faeroes Medical	19/04/2021	12/04/2021	11/05/2021	Claim Approved By Commissioner Approver	£3694.00	View
679	Commissioner claim for Provider: Faeroes Medical	17/04/2021	13/04/2021		Pending Commissioner User Approval	£1080.00	View
678	Claim from Faeroes Medical	01/04/2021	12/04/2021		Pending Commissioner User Approval	£1554.00	View

The claim has now been sent to the Commissioning Organisation for approval. This will consist of two tiers of approval:

Tier 1 Commissioner User – Approving the Claim
Tier 2 Commissioner Approver – Approving for Payment

16. The tier 1 Commissioner User will review the claim, including any evidence and approve the claim. This will then be sent to the Commissioner Approver.

Claim Components

Service	Component	Activity Window	Status	Tariff	Units/Achievement	Estimated Value	Evidence	Approve	Decline	History
Anti Coagulation Therapy	Anti Coagulation Therapy01	2021-2022 - Month 10	Pending Internal Approval	£180.00 Per Unit	6	£ 1080.00	👁	☐	☐	

C Reset Form　　🖫 Save For Later　　→ Decline　　→ Submit Claim

17. The tier 2 Commissioner Approver will also review the claim by double checking the included evidence documentation, and most importantly the claim amount. Once they are satisfied with this information they will click to **certify** the claim can be approved before clicking on the **Approve For Payment** button.

19. Bulk Claims

This option is available to Commissioning Organisations who makes claims on behalf of their Service Providers. This is the ideal option if you are processing multiple claims for multiple provider. If you are only submitting a small number of claims, you may wish to use the Commissioner Submission on Behalf of a Service Provider option.

Before carrying out this task it is essential that you are familiar with all the steps involved in a Commissioner creating a service, adding components and publishing it. For information on this, please refer to A Commissioner creating a Service.

When undertaking a Commissioner Submission, it is expected that both the person submitting the claim and the Service Provider are in full agreement to this being carry out and that steps are in place to provide all relevant supporting evidence where this has been requested.

This function can only be carried out by a Commissioner User (tier 1)

Also note that Bulk Claims can only be made as per the schedule. See an example below:

Claim From	Claim To
01 Jan 2023	31 Jan 2023
01 Apr 2023	30 Apr 2023

1. At the point of service creation, make sure that the box is ticked for 'Claims Submitted On Behalf Of Practice By Commissioner'. For guidance on creating a service, adding the components and offering these out to your practices, please refer to section 11. A Commissioner Creating a Service.

2. When the service is ready, click on the Bulk Claims link from the upper right hand side of your screen.

3. Click on the Create Template menu tile.

4. The first tab that opens is Services. Select your service and use the Select button to multi-select your components.

5. Next is to select the **Providers** tab. Please note that Provider and Service combinations where the Provider does not actually provide the service will be filtered out of the template.

6. Search for your Provider or use the blue Select button to select all of your providers.

7. Now select the **Download** tab followed by clicking on the **Download** button.

8. Your file will download to your computer and can be located either in the bottom left hand corner of your screen or is locatable in your downloads. You can access your downloads by simultaneously pressing both the Windows key and the letter 'E' on your keyboard and navigating to your downloads section.

9. Open the file up and use the Save As function and save the file on your computer/network.

10. Fill in the numbers achieved in each of the cells in column H. Remember to save any changes you have made.

	A	B	C	D	E	F	G	H
1	ProviderId	ComponentId	ContractId	Provider	ODS	Service	Component	Claim
2	1515	1465	258	VALLEY MEDICAL	P58490	RISK_STRAT01	01. VERY HIGH RISK	12
3	1515	1466	258	VALLEY MEDICAL	P58490	RISK_STRAT01	02. HIGH RISK	10
4	1515	1467	258	VALLEY MEDICAL	P58490	RISK_STRAT01	03. MEDIUM RISK	14
5	1515	1468	258	VALLEY MEDICAL	P58490	RISK_STRAT01	04. LOW RISK	30
6	1581	1465	258	STRANDHILL HEALTH CARE	P75028	RISK_STRAT01	01. VERY HIGH RISK	20
7	1581	1466	258	STRANDHILL HEALTH CARE	P75028	RISK_STRAT01	02. HIGH RISK	15
8	1581	1467	258	STRANDHILL HEALTH CARE	P75028	RISK_STRAT01	03. MEDIUM RISK	20
9	1581	1468	258	STRANDHILL HEALTH CARE	P75028	RISK_STRAT01	04. LOW RISK	15
10	1633	1465	258	CABLE BAY FAMILY PRACTICE	P01007	RISK_STRAT01	01. VERY HIGH RISK	30
11	1633	1466	258	CABLE BAY FAMILY PRACTICE	P01007	RISK_STRAT01	02. HIGH RISK	40
12	1633	1467	258	CABLE BAY FAMILY PRACTICE	P01007	RISK_STRAT01	03. MEDIUM RISK	25
13	1633	1468	258	CABLE BAY FAMILY PRACTICE	P01007	RISK_STRAT01	04. LOW RISK	15

11. Next is to click on the **Bulk Claims** link.

Home > Bulk Claims > Create Template

Services   Providers   Download
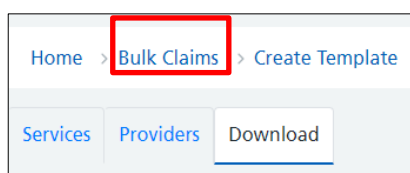
12. Click on the **Upload Template** menu tile.

Upload Template

Upload, validate, and create claims from your populated 2022 - 23 template
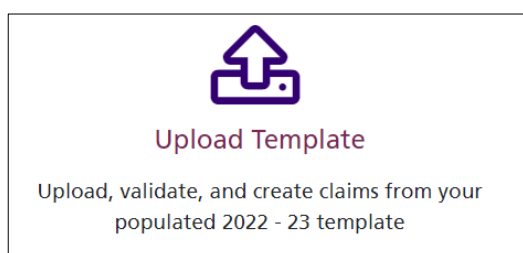
13. Click on the **Browse** button and locate the file you have saved.

Choose file...   Browse

Valid File Types: *.csv

⚖ Validate / Upload

14. Once the file has been uploaded, click on the **Validate/Upload** button.

Bulk_Claim_Template_01_01_2023.csv   Browse

Valid File Types: *.csv

⚖ Validate / Upload
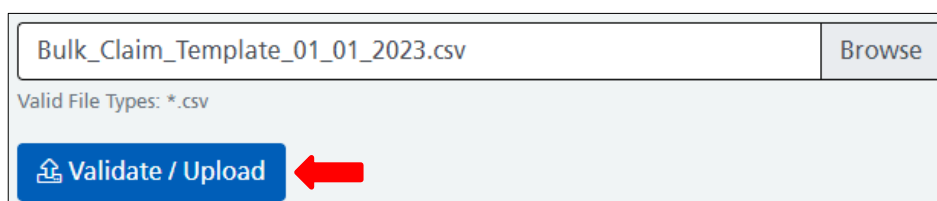
Date	Provider(ODS): Service - Component	Claim Units	Empty Claim	Evidence Required	OutSide Claim Window	Existing Claim	No Service	No Domain
44927 VALLEY MEDICAL (P58490: RISK_STRAT01 - 01. VERY HIGH RISK		4						
44927 VALLEY MEDICAL (P58490: RISK_STRAT01 - 01. VERY HIGH RISK		3						
44927 VALLEY MEDICAL (P58490: RISK_STRAT01 - 01. VERY HIGH RISK		2						
44927 VALLEY MEDICAL (P58490: RISK_STRAT01 - 01. VERY HIGH RISK		1						
44927 STRANDHILL HEALTH CARE (P87028): RISK_STRAT01 - 01. VERY HIGH RISK		4						
44927 STRANDHILL HEALTH CARE (P87028): RISK_STRAT01 - 01. VERY HIGH RISK		3						
44927 STRANDHILL HEALTH CARE (P87028): RISK_STRAT01 - 01. VERY HIGH RISK		2						

15. Finally, click on the **Create Claims** button.

→ Create Claims

⚠️ If you notice this particular symbol it means that there is already an existing claim for this practice. You will then need to place a tick in the box.

> Some services already have a claim. Please confirm this is OK, or correct and reupload the file.
> ☐ I understand services with an existing claim will be ignored

Important Information – Single and Multi-Level practices

These claims will now have a status of Pending Second Commissioning Review for single-level practices.

These claims will now have a status of Pending Provider Review for multi-level practices. Once this claim (s) has been approved by the Provider Approver, the status will change to Pending Second Commissioning Review.
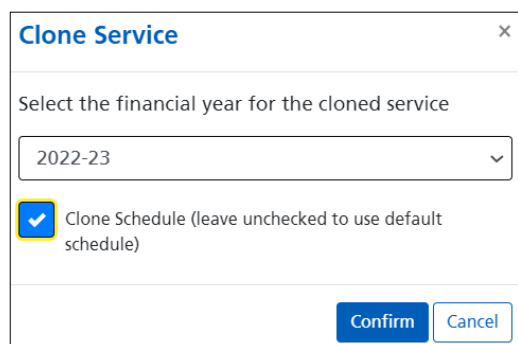
20. Cloning and Editing a Current Service (in the current financial year)

A service will need to be cloned if, for example, a Commissioner had offered out a service and decided to change something within that service – whether it be a change to the claim frequency from monthly to quarterly, a change of schedule or an amendment of a tariff.

A cloned service must have a unique name. The system will inform you that the name already exists when attempting to use the same name.

The example below will look at a scenario where a Commissioner published and offered out a service and afterwards realised that one of the components had an incorrect tariff.

1. Click on **Services** from the CQRS Local home page.

2. Find your Service and then click on the **View** button.

3. Scroll down to the bottom of the screen and click on the **Clone** button.

4. You will be asked to select the financial year for the cloned service and also if you wish to clone the same schedule. This will retain the claim frequencies that you had previously entered.

5. Click on the **Confirm** button.

Clone Service ✕

Select the financial year for the cloned service

| 2022-23 ⌄ |

✔ Clone Schedule (leave unchecked to use default schedule)

Confirm Cancel

4. The Name and Description will need to be amended. If, for example, your service name was Inclusion Health 22-23, consider changing it to Inclusion Health 2022-23 to keep it unique.

5. Click **Save** to save these changes.

6. On the Services page, click the **Edit** button adjacent to the service you have made a change to.

Service Name ⬆⬇	Paycodes ⬆⬇	Commissioner Submission	Date From ⬆⬇	Date To ⬆⬇	Status ⬆⬇	Components ⬆⬇	Action
Inclusion Health 2022-23	Demand Management [ZDEMMA,ZDEMMG,ZDEMMP]		01/04/2022	31/03/2023	Draft	1	Edit
Inclusion Health 22-23	Demand Management [ZDEMMA,ZDEMMG,ZDEMMP]		01/04/2022	31/03/2023	Published	1	View

7. Click on the **Components** tab and click on the **Edit** button.

Name	Description	Tariff Currency	Base Tariff	Frequency	Claim Schedule	Start Date	End Date	Evidence Required	
Holistic Screening and Health Assessment	Providing holistic screening and health assessment to understand the social and health needs of the person beyond their immediate complaints.	Per Unit	£75.00	Quarterly	Standard	01/04/2022	31/03/2023	No	Schedule Clone Edit 🗑

8. Make the necessary edits to the component and click on the **Save** button.

Component ✕

Name

Holistic Screening and Health Assessment

Tariff Currency

Per Unit

Description

Providing holistic screening and health assessment to understand the social and health needs of the person beyond their immediate complaints.

Base Tariff (£)

75.00

Claim Frequency

Quarterly

9. Click on the **Review** tab in the upper left hand corner of the page and select to confirm you wish to publish this service.

10. Click **Publish.**

The next step is to amend the current contract to include this revised one.

11. Select **Contracts** and **View** the Contract which includes the original Service.

12. Select **Amend** at the bottom of the page.

13. Click **Confirm** to amend the contract.

14. Select the **Services** tab and locate the original service.

15. Remove the Original Service by unticking the box (es).

16. Find your newly edited Service and place a tick into the components box (es) and untick anything in the old service.

Inclusion   ↻ 🔍   Select Deselect

Select All That Apply (1 Selected)

Inclusion Health 2022-23 (APMS,GMS,PMS) 2022 - 23   Select Deselect

☑ Holistic Screening and Health Assessment   ✔

Inclusion Health 22-23 (APMS,GMS,PMS) 2022 - 23   Select Deselect

☐ Holistic Screening and Health Assessment ❶   ✘

↻ Cancel   ↻ Reset Form   Previous ◁   Next ▷   ↻ Cancel Amend   ✓ Confirm

17. Select to confirm you wish to send this contracted activity to the selected providers and click the **Confirm** button. You will then receive confirmation it has been successfully amended and is now live.

| Contract Details | Providers | Services | **Review** |

Contract Name

Inclusion Health 22-23

Start Date

01/04/2022

End Date

31/03/2023

| Contract Details ✔ | Providers Selected ✔ | Components Selected ✔ | Component Dates Valid ✔ | Contract Types Match ✔ |

Providers ②

CABLE BAY MEDICAL PRACTICE (T91004, GMS)
TABLEY MEDICAL CENTRE (T91603, GMS)

Services & Components ①

+ [Inclusion Health 2022-23] - Holistic Screening and Health Assessment
− [Inclusion Health 22-23] - Holistic Screening and Health Assessment

☑ Select to confirm you wish to send this contracted activity to the selected providers (once confirmed, contracted activity will be live and providers will be able to submit claims against service components)

↺ Cancel | ⟳ Reset Form | Previous ⊲ | ↺ Cancel Amend | ✔ Confirm

21.   Cloning a Service into a New Financial Year

This guide will assist Commissioning Organisations to clone a service into the next financial year and have the system ready for GP practices to make their claims from April onwards.

Before you do this, it is advised to have confirmation of the following:

a) Tariff – will this increase for the new financial year?
b) Service Specification – has this been revised in anyway?
c) Will the claim frequencies – i.e. monthly or quarterly change in anyway?
d) Are you wishing to add any more components to the service?

The below example will demonstrate the cloning of a Minor Surgery Service into the next financial year.

1. Click on the **Services** menu tile from your home page.

2. Find your Service and then click on the **View** button.

3. Scroll down to the bottom of the screen and click on the **Clone** button.

4. Select the new financial year the service will be cloned into.

Clone Service ✕

Select the financial year for the cloned service

2022-23 ⌄

2022-23
2023-24
2024-25
2025-26
2026-27

Confirm | Cancel

5. Place a tick into the **Clone Schedule** if you wish to copy over the previous schedule. If you are unsure you will be able to edit the schedule in section 16 below.

6. Click on the **Confirm** button.

Clone Service

Select the financial year for the cloned service

2023-24

☑ Clone Schedule (leave unchecked to use default schedule)

Confirm | Cancel

7. Edit the Service Name. You may wish to put the financial year at the end of the name. Copy this and paste it into the description too.

Edit Service Details

Name

Minor Surgery Service - 2023-24

☑ Use PCSE for payments

Description

Minor Surgery Service - 2023-24

8. Use the **Browse** button, locate and upload your revised Service Specification document (s).

9. Click on the **Save** button to save the new changes you have made.

10. Use the search box to locate your service. You will also need to change the financial year too.

Service Name ↑≡	Paycodes ↓↑	Commissioner Submission	Date From ↓↑	Date To ↓↑	Status ↓↑	Components ↓↑	Action
Minor Surgery Service - 2023-24	Minor Surgery DES [DEMSUG,DEMSUA,DEMSUP]		01/04/2023	31/03/2024	Draft		Edit

Page 1 of 1 - showing 1 of 1 items matching 'Minor Surgery Service - 2023-24' of 1 total

11. Click on the **Edit** button.

12. Next is to take a look at the service components. Click on the **Components** tab in the upper left hand corner of your screen.

13. The component screen will then be displayed. From this screen we can begin to make our changes if required to each of the components.

14. To make any changes, click on the **Edit** button.

Name	Description	Tariff Currency	Base Tariff	Frequency	Claim Schedule	Start Date	End Date	Evidence Required				
A. Excisions	Please enter the number of excisions undertaken	Per Unit	£90.00	Quarterly	Standard	01/04/2023	31/03/2024	No	Schedule	Clone	Edit	🗑
B. Incisions	Please enter the number of incisions undertaken	Per Unit	£90.00	Quarterly	Standard	01/04/2023	31/03/2024	No	Schedule	Clone	Edit	🗑
C. Injections	Please enter the number of injections	Per Unit	£45.00	Quarterly	Standard	01/04/2023	31/03/2024	No	Schedule	Clone	Edit	🗑
D. Declaration: I confirm that the information being submitted is to the best of my knowledge and that the ICB may undertake an audit at any time to verify this information	Please tick the box to confirm the declaration	Retainer	£0.00	Quarterly	Standard	01/04/2023	31/03/2024	No	Schedule	Clone	Edit	🗑
E. Proof of Certification	Please upload you proof of certification	Retainer	£0.00	Annually	Standard	01/04/2023	31/03/2024	Yes ⓘ	Schedule	Clone	Edit	🗑

15. If you need to make any changes to the Base Tariff, you can do it from this screen. Now click **Save**.

ℹ️ If you have decided to change the Claim Frequency, from quarterly to monthly for example, you will have to delete the component and re-add it. Remember to number or letter the component if this is what you have previously done.

16. It is now advisable to check the schedule to ensure that the dates are OK. To proceed to this, click on the **Schedule** button.

17. If you wish to amend any of the dates, you can do this by clicking on the **Edit** button. When you have made your required changes, click on the **Save** button.

Name	Activity From	Activity To	Claim From	Claim To	
2023-2024 - Quarter 1	01 Apr 2023	30 Jun 2023	01 Jul 2023	30 Nov 2023	✏️ Edit
2023-2024 - Quarter 2	01 Jul 2023	30 Sep 2023	01 Oct 2023	14 Oct 2023	✏️ Edit
2023-2024 - Quarter 3	01 Oct 2023	31 Dec 2023	01 Jan 2024	14 Jan 2024	✏️ Edit
2023-2024 - Quarter 4	01 Jan 2024	31 Mar 2024	01 Apr 2024	14 Apr 2024	✏️ Edit

18. Next is to review your service and to publish it. Click on the **Review** tab in the upper left hand corner of your screen.

19. Ensure that everything is correct and then place a tick in the **confirmation box** followed by clicking on the **Publish** button.

Please note that once published, services and components cannot be edited. If you discover that you have made a mistake after publishing the service, you will need to re-clone it. If this is the case, please return to the beginning of this document and start again. You won't be able to use the same service name again. Please consider changing the year from 2023-24 to 2023-2024 for example.

Creating a new Contract

You will now need to proceed with creating a new contract and making this service available to your service providers.

21. Click on the **Contracts** tab in the upper right hand corner of your screen.

22. Click on the **New Contract** button.

23. Enter the Contract Name (this is the name of the Service)

24. Make sure that you select the correct Financial Year

25. Once this has been done, Click on **Next.**

26. Next is to select the providers who will be undertaking this service. You can use the **Select** button to multi-select all practices or you can select them individually.

27. Once you have selected your providers, you can either click on the **Services** tab at the top of the screen, or alternatively click on the **Next** button at the bottom of the screen.

28. You can search for your service by either searching for it as shown below or you can search for it by scrolling through your services list.

29. When you have located your service, use the **Select** button to select all the components in your service.

30. Click on the **Next** button.

31. Confirm that all the information is correct. This should include:

a) You have the correct Contract Name
b) The start and end date are for the correct financial year
c) The correct Providers have been selected – a number in a grey box will show you the total
d) The correct Services & Components are displayed

32. Lastly, place a tick in the **confirmation box** followed by clicking on the **Confirm** button.

This process will need to be repeated for each and every service that will require cloning over into the next financial year. If you are having difficulties with this and require assistance, please raise a call with our Service Desk. Their details can be found at the bottom of this document.

22.   Extending the Claims Window

If a claim window has been missed by a Service Provider, the Commissioner can extend this date up to 21 days to allow extra time for Service Providers to submit their achievement. This action can be undertaken by both a Commissioning User and Approver.

1. From your CQRS Local home page, click on the **Services** menu tile.

2. Click on the **View** button on the service you are going to extend.

3. Click on the **Components** tab.

4. Click on the **Claim Extension** button (this will need to be repeated for each component).

5. Using the drop down arrow, select the number of days you are allowing to extend for that particular month (s) or quarter (s) then click **Save.**

6. The claim extension has been successfully added.

23.   Re-activating an Expired Claims Window

Re-activating an expired claims window will give the Service Provider the opportunity to submit a claim which has expired.

1. Click on the **Claims** option from the top of the screen.

2. Click on the **Reactivate** button.

ID	Provider	ODS Code	Submission Date	Approval Date	Status	Estimated Value	Rating	Action	
11290	VALLEY MEDICAL	P50536			Claim Window Expired	£385.00	Low Risk	Reactivate	View

3. Enter the number of days you wish to extend the claim window.

Claim Reactivation ×

To reactivate the expired claim, we must extend the claim window on all the components included in the claim.

Service : Component

Acupun 01 : Acup

The maximum claim extension is 21 days. As the claim has already exceeded the window by 3 days, the selected extension must be at least 1 day later.

Choose how many days to extend the claim window.

4 ˅

➡ 🖫 Save ✕ Close

The Commissioner will be able to extend the claim by up to 150 days.

The particular example indicates that the claim exceeded the window by 3 days which means that the Commissioner can extend the claim by 21 days, leaving 1 day after this extension. Please follow the guidance on the screen when you undertake this exercise.

4. Click **Save**.

5. The claim will now be automatically re-opened for the Service Provider to submit their achievement.

24.   Searching for a Claim using the Claim ID or Name

Searching for a Claim using the Claim ID or Name is a convenient way of locating and keeping track of any particular claim. This might be a query raised by a Service Provider relating to a claim for example.

1. For both Commissioning Organisations and Service Providers click on **Claims** located at the top right hand side of your screen.

2. Enter in your Claim ID or Claim Name and click the magnifying glass.

#	10 ⬍	Search Claim ID or Claim Name	➡ 🔍

25.   Reporting – By The Commissioner

Reporting is a convenient way to keep an eye on the financial activity per Service and Service Provider for a specific timeframe and a report can be available in just a few clicks. Any CQRS Local user can access these reports.

1. Firstly, click on **Reporting**, located at the top right-hand side of your screen.

Services   Contracts   Claims   Bulk Claims   Providers   **Reporting**   👤

2. From there you will see 5 reports. These are:

Report Name	Purpose
Claims Approved For Payment	Generate Claims Approved For Payment Report
Claims Pending For Payment	Generate Claims Pending For Payment Report
No Claims Submitted	Generate No Claims Submitted Report
Claimed Services	Generate Claimed Services Report
Provider Users	Generate Provider Users Report

Let's take a look at each of these reports.

3. Select the first report - **Claims Approved For Payment**

4. To expand your search criteria, click on the **Parameters** button.
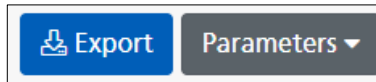
You will then be presented with the following parameter selection.

Each of the sections below will be explained:

Search By:
Created Date (Claim Date) - This is the date the claim was created by the Service Provider
Submission Date - This is the date the claim was submitted by the Service Provider
Activity Date - This is the Activity Window - i.e. 2022-2023 - Month 4
Approval Date - This is the date the claim was Approved by the Commissioner

Search Dates: You can specify the period of time – whether this is the previous month or quarter or any other date parameter.

Services & Components: You can specify any number of services and their components. For example you may wish to run a report on Minor Surgery and its 4 components – *Excisions, Incisions, Injections and Aspirations.*

Displayed Columns: This will allow you to include any of the following headers in your report. *Claim Date, Service, Component, Claim Activity, Claim Tariff and Claim Value.* All 6 are auto-selected by default. If you don't wish to include all of them, simply untick them.

Horizontal Scrolling: Choose how you would like your report to display. There is a button to toggle Yes or No.

Items Per Page: Choose how many items you require per page. This ranges from 20 to 1,000.

5. Click on the **Update** button to display your chosen report criteria. You can use the Export button which will export the report into a CSV output file.

The following report has displayed claims made by a particular provider for Near Patient Testing along with a claim value.

To go back to the reporting page, click on **Reporting** from the upper right hand side of the screen.

6. Select the next report - **Claims Pending For Payment**

This report will allow you to look through all your claims where they are pending for payment. Your report will show you the following statuses:

- Pending First Commissioning Review
- Pending Second Commissioning Review
- First Review Declined
- Second Review Declined

Again, please use the Parameters button to tailor the report to your requirements.

In the first instance it would be ideal for Service Providers to look through claims which are either First or Second Review Declined and to action these and submit for Commissioner Approval. Remember, there will be a reason the claims (s) was declined in the history icon in the claims page.

7. Select the next report - **No Claims Submitted**

This will provide you with information where a Service Provider hasn't submitted any claims for a selected period of time. Service Providers are reminded that even if they haven't undertaken any work for a particular service, they should enter a zero into the Units and submit their claim.

8. Select the next report - **Claimed Services**

This report shows you all the Services that your Service Providers have claimed for and what the status of these claims are. Currently there are the following headers:

- Unsubmitted Claims
- Submitted Claims
- Pending Claims
- Approved Claims
- Rejected Claims
- Expired Claims
- Has Claimed?

The below example shows that for the Minor Surgery Service, 10 have been submitted, 9 of which are Pending (payment) and 1 has been Approved (for payment), none of these have been rejected (declined) or have expired (missed claims window).

Claimed Services   Export | Parameters ▾

Service ⬇	Unsubmitted Claims ⇅	Submitted Claims ⇅	Pending Claims ⇅	Approved Claims ⇅	Rejected Claims ⇅	Expired Claims ⇅	Has Claimed? ⇅
Minor Surgery Service - 2023-24	0	10	9	1	0	0	✓
Total Claims	0	10	9	1	0	0	

First Previous 1 Next Last

Displaying 1 of 1 rows

9. Select the next report - **Provider Users**

This particular report is useful for Commissioners who wish to view all practice system users and the status of their account. The report includes the following headers:

Organisation Name, Ods Code, Role, First Name, Last Name, Email, Email Confirmed, Approved, Revoked, Revoke Reason, Disabled, Disable Reason.

26. Schedules (Claim Windows)

Claim Windows are set up by default to use the NHS Standard Contract. These dates are configurable and may be amended by the Commissioning Organisation to mirror your current contract (s). The below image displays a monthly schedule. For instances of a quarterly, bi-annual or annual contract the schedule will display the time frames for these periods too.

A. **Name** – this is the claim year and shows quarters 1 to 4.

B. **Activity From** – this is the start date of the month you will be claiming from.

C. **Activity To** – this is the end date of the month you will be claiming to.

D. **Claim From** – this is the period of time for the start of a claim submission and commissioner approval.

E. **Edit** – See below.

Changing the Claims Window

As a Commissioner it is your choice whether or not to amend these dates. You may wish to keep dates in-line with your current contractual dates. Amending them is very straight forward and if the editing of these dates is a requirement, this can be done when adding the components when a service is being created. The following instructions will guide you through this.

1. Click on the **Schedule** button.

2. The **Edit** button will then allow you to make your date amendments.

3. Amend your dates followed by clicking on the **Save** button. You will need to repeat this process for each quarter/month.

If you forget to amend these dates and the service is live, you will need to clone the service and amend the dates within the schedule on the components page. Please refer to the section Cloning and Editing a Current Service for guidance.

27. Administration – Account Management

To access the Administration guide, please visit our Academy site which can be accessed here.

28. System Statuses

Below are common CQRS Local system statuses and a brief explanation as to their meaning.

Notification Type	Meaning
Service Created	A brand new service has been created. For example, Minor Surgery.
Service Published	The service and components have been added and it is ready to be offered out to Service Providers.
New Contract	The contract is the service and agreement available to a participating Service Provider
Pending Internal Approval	Awaiting Approval from a Provider Approver. This is the status that the Service Provider will see.
Pending System Approval	A claim has been submitted by a SP User to a SP Admin. This is the status that the Service Provider will see.
Pending System Review	If a claim has been submitted with a supporting document, the file (s) will be scanned through an anti-malware check first. The status will change after a minute or two ad will display 'Pending First Commissioning Review'.
Pending First Commissioning Review'	The Service Provider has submitted their claim and is waiting for the First Commissioner (tier 1) to approve the claim
Pending Second Commissioning Review	The Service Provider has submitted their claim and is waiting for the Second Commissioner (tier 2) to approve the claim.
Claim Approved	The claim has now been approved for payment by the Commissioner
First Review Declined	Tier 1 Commissioner has declined the claim.
Second Review Declined	Tier 2 Commissioner has declined the claim.
Commissioner Approver Declined	Tier 2 commissioner approver has declined the claim.
Component Nearing End	The claim window for your component (s) is due to expire shortly. A notification will alert you that there is less than 48 hours left to submit the Claim.
Claim Period Expired	The claim window for your component (s) has expired - you will need to process it again next month.
Unclaimed Component	Alert that (service name) has not been claimed. A notification will alert you there is less than 48 hours left to make a claim.
Internally Declined	This is where a Provider Approver has declined a claim.

29. Glossary of Terms

Please find some useful information listed below to help you understand what some of the functionality will do as well as explaining what certain terms and phrases mean.

Term/System Function	Explanation
Tasks & Notifications	A Task is something that requires an action. For example, approving a payment. Notifications are advice/reminders. For example, you will receive a notification if there is less than 48 hours left to make a claim.
Published Date	This is the date that the Service was published (made available for Service Providers) by the Commissioner.
Cost Centre	This is the department at the Commissioning Organisation that finance payments will come from to pay a Service Provider.
Commissioner Submission	Some Commissioning Organisations will ask CSUs to submit claims on behalf of certain Service Providers and this particular function is for use by CSU staff.
Service Provider	A GP practice.

Services	Also known as Schemes. These are local to your area and will depend on which services are on offer. These could be: Wound Care, Cardiovascular health checks, Post-op suture removal, Warfarin prescribing etc.
Bandings	There are 2 banding types - Static Activity and Static Percentage which are usually used for performance related payments. Commissioners could use the Static Activity where achievements that meet a certain threshold will determine a higher financial return for the provider. Static Percentage is when performance will be related to percentage complete and based upon them will return a different tariff amount. A sliding scale can also be used whereby every single step up determines a different tariff amount.
Service Class	These are Local Incentivised Services, Local Enhanced Services, QOF or Other.
Components	The Commissioner adds Components for which a Service Provider can claim against – these can be - incisions, excisions, injections etc.
Provider	The GP practice/Service Provider.
Create New Claim	The Service Provider user would input all the required information in order to make a claim.
Pending Internal Approval	This is at the point where a Service is requiring approval from a Service Provider Approver (Practice or Business Manager).
Claim ID	All claims have a Claim ID which can be referenced at any time or used to search for a particular claim.
Tariff Currency - Actual and Weighted	Age and sex of the patients as well as any in nursing or residential care, additional patient need due to medical conditions, patient turnover and unavoidable costs based upon rurality and staff market forces for the area. This results in an adjusted count of patients known as the "weighted patient count." (Therefore, 'actual' practice population is the number of registered patients with no weighting/adjustment applied.)
Base Tariff	If you choose, for example, Per Unit for the Tariff Currency and pay a Base Tariff of £10, this will in theory will mean that you will pay £10 per patient or per test etc.
Claim Schedule	These are the periods of time set by the Commissioner. These may be monthly payments and therefore 12 months are created in a schedule. The Commissioner would input for example for Month 1 - From 01/04/2020 to 30/04/2020.
Claim Window	The Service Provider will have a certain period of time to submit their claim to the Commissioner and the Commissioner will have a certain period of time to approve the claim.
Contract Basis Code - Confirmed & OptIn	Confirmed means auto confirmed where a provider is automatically confirmed to participate and opt-in is where a practice will have a choice of saying Yes or No. This function will not be used in CQRS Local - For CQRS National only.
Per Unit	Per Unit is coding that persons medical records to claim and then reporting on these numbers for evidence. It could also be referred to as: Per Patient or per test.
Retainer	Retainer is that you will deliver a service no matter how many people you see. A Commissioner may ask for evidence to be provided of tests completed. There may be a certain number for the Commissioner to honour payment. These are usually payable yearly.
Commissioning Organisations	They are responsible for commissioning Quality Services
Quality Services	Quality Services include QOF, DES and V&I but also locally commissioned Quality Services
Commissioner	This will mean your Commissioner or someone from the Commissioning Organisation who deals with your Services, Contracts and Payments

Minimum Viable Product	A minimum viable product (MVP) is a development technique in which a new product or website is developed with sufficient features to satisfy early adopters. The final, complete set of features is only designed and developed after considering feedback from the product's initial users
Contracts	A contract is an arrangement between the Commissioning Organisation and the Service Providers (GP practices).
Claims	This is what the Service Provider is requesting for payment.
Claim Name	This will show you which Service Provider the claim is for and may read something like "Commissioner Claim for Humber Medical Centre".
Bulk Claims	Bulk Claims is a convenient way of undertaking mass claims and can save the Commissioner a lot of time and effort.
Reporting	This functions allows you to generate a report for certain activities. For a Commissioning Organisation you can, for example, run a report on the number of incisions/excisions claimed by one or all Service Providers over a certain timeframe. For a Service Provider you can run a report on the number of claims approved/declined over a certain period of time or instances where a claim window has expired. Reports can then be downloaded to CSV format and electronically filed away.
Claim Frequency	You can specify when a Service Provider can make a claim for these Components. The frequencies are: Monthly, Quarterly, Bi-Annually or Annually.
Evidence Required	A Commissioner may request that a Service Provider supplies and uploads evidence to support these claims. The Commissioner will indicate in the grey box what type of evidence is required and in what preferred format this is to be produced in.

30.   Acronyms

Below is a list of acronyms used in CQRS Local which are listed alphabetically. Please note that there may be some acronyms listed here that only exist in CQRS National. There are also acronyms listed here relating to the CSUs who are part of the Collaborative.

For convenience, the acronyms have been placed in alphabetical order.

Acronym	Meaning
A&G	Arden & GEM CSU
API	Application Programming Interface
AUA	Avoiding Unplanned Admissions
CC	Core Contact
CO	Commissioning Organisation
CQRS	Calculating Quality Reporting Service
CRP	Contractor Registered Population
CSU	Commissioning Support Unit
DES	Directed Enhanced Service
ES	Enhanced Service
GDS	Government Digital Service
GPDC	General Practice Data Collector
GPES	General Practice Extraction Service
GPPCF	GP Payments Calculations Futures
HSCN	Health and Social Care Network
ICB	Integrated Care Board

Acronym	Meaning
ICS	Integrated Care Systems
IIF	Investment and Impact Fund
ISFE	Integrated Single Financial Environment
LCS	Locally Commissioned Services
Acronym	**Meaning**
LES	Local Enhanced Service
MESH	Message Exchange for Social Care and Health
MLCSU	Midlands and Lancashire CSU
MVP	Minimum Viable Product
NCD	Network Contract DES
NECS	North of England Commissioning Support Unit
NEL	North East London CSU
NHAIS	National Health Applications and Infrastructure Services
ODS	Organisation Data Service
ORD	Organisation Reference Data
PCD	Patient Confidential Data
PCSE	Primary Care Support England
QOF	Quality Outcomes Framework
RLO	Regional Local Office
SCW	South, Central and West CSU
SFI	Standing Financial Instructions
SP	Service Provider
SPO	Service Provider Organisations
STP	Sustainability and Transformation Partnership
V&I	Vaccinations and Immunisations
WPLS	Weighted Practice List Size

31.   Frequently Asked Questions

Please click on the below link to see a list of all the FAQs.

https://academy.midlandsandlancashirecsu.nhs.uk/cqrs-local-training-1/

32.   Useful Links

Further Training - CQRS Local – Video Tutorials

You can also find additional training resources in the CQRS Learning Centre.

https://academy.midlandsandlancashirecsu.nhs.uk/cqrs-local-training-1/

Help & Support

The CQRS service desk are here to answer any questions you may have. Please contact us. Our contact details are:

Telephone: 0330 124 4039 *open 8am-6pm Mon-Fri (excluding public holidays)*
Email: support@cqrs.co.uk

Commissioner Engagement events

This was held in October 2022. A video of the event with a system demonstration is available to view **here**.